



HARRISON PHYSICAL THERAPY, P.C.

1505 Route 52, Suite 12 · Fishkill, NY 12524 · Phone: (845) 896-3750 · Fax: (845) 896-5728

PATIENT INFORMATION--MEDICARE

Name: _____ Today's Date: _____
Last First Middle Initial

Address: _____
Street City State Zip

Bill to: _____
Street City State Zip

Phone: () _____ E-mail: _____ Soc. Sec. #: _____ - _____ - _____

Marital Status: Single ___ Married ___ Other ___ Birth Date: _____ Patient Sex: M F

Occupation: _____ Status: Employed ___ Retired ___ Student ___ Not Working ___

Employer Name: _____ Phone: () _____

Address: _____
Street City State Zip

Primary Care Physician: _____ Referring Physician: _____

Date of Injury: _____ Is this injury Job-Related? Y N or Automobile Accident-Related? Y N

Have you had any physical therapy this year? Y N Are you currently having home physical therapy? Y N

How did you first hear about Harrison Physical Therapy? _____

In case of emergency, contact: _____ Phone: () _____

Medicare Number: _____

You are responsible for the first \$233 for the new year and any applicable copayments or coinsurance for your secondary insurance company, or the full 20% if no secondary insurance co. is involved. Please also note that beginning January 1, 2022, Medicare has implemented a \$2,150 threshold on physical therapy reimbursement.

Secondary Insurance: _____ Phone: () _____

Address: _____
Street City State Zip

Insured's Name: _____ Relation to Insured: _____

Group # _____ ID # _____ Attn: _____

I hereby certify that all information is true to the best of my knowledge, and I am responsible for all charges incurred for these services. Late payments may be subject to 1.5% finance charges. I hereby authorize the release of any medical information necessary to process my claim and authorize my insurance company to pay Harrison Physical Therapy, P.C. directly for services rendered.

Patient's Signature: _____ Date: _____



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Patient Name: _____

Date: _____

Indicate below if you now have or have ever had any of the following:

<u>Condition</u>	<u>Y / N</u>	<u>Explanation with Dates</u>
Breathing Problems	Y / N	_____
Cancer	Y / N	_____
Dental Problems	Y / N	_____
Diabetes	Y / N	_____
High Blood Pressure	Y / N	_____
Blood Vessel Disease	Y / N	_____
Heart Attack	Y / N	_____
Pacemaker	Y / N	_____
Headaches	Y / N	_____
Hearing Aid	Y / N	_____
Joint Replacements	Y / N	_____
Metal Implants/Fragments	Y / N	_____
Arthritis	Y / N	_____
Nervous System Disorder	Y / N	_____
Visual Impairment	Y / N	_____
Allergies	Y / N	_____
Previous Surgeries	Y / N	_____
Seizures	Y / N	_____
Infectious Disease	Y / N	_____
Smoker	Y / N	_____
Fractures	Y / N	_____
Skin Condition	Y / N	_____
Open Wounds	Y / N	_____

Are you currently pregnant: Y N

List all current medications and the condition(s) for which they are being taken:

The above is correct to the best of my knowledge.

Patient's Signature

Date: _____



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WELCOME

Harrison Physical Therapy, P.C. is dedicated to providing high quality, individualized care to each of our patients in an environment that makes rehabilitation a truly enjoyable and positive experience. Each patient is educated about their condition, while being instructed in a personalized, progressive therapy program designed to produce significant measurable improvement in their condition, achieve their personal goals, and attain their highest level of function.

Your doctor has prescribed physical therapy, which is an ongoing process that requires regular attendance to be optimally effective. Consequently, not attending scheduled sessions may inhibit your ability to attain your full rehabilitation potential.

We at Harrison Physical Therapy, P.C. believe that clear communication with your prescribing physician is essential to optimize your rehabilitation. Please notify us at least one week in advance of any visit to your prescribing physician, so that we can perform a reevaluation and send a progress note.

APPOINTMENT POLICY

Please arrive on time for your appointments so that you can receive your full scheduled treatment. If you arrive later than 15 minutes past your scheduled appointment time, your treatment may be shortened or cancelled.

Please notify us at least 24 hours in advance if you need to cancel your appointment. Failure to do so may result in a \$25 charge.

INSURANCE RESPONSIBILITY

Although we are familiar with most of the larger insurance plans, each policy is individual with regard to its specific provisions. It is the patient's responsibility to verify their percentage of payment per visit, any co-payments or deductibles, and limits of visits per calendar year. As a service to our patients, we at Harrison Physical Therapy, P.C. will be glad to submit your insurance claims for you, but you are responsible for any portion not paid by your insurance. If you need any assistance in this matter, please feel free to speak with the office staff.

I have read and understood, and agree to comply with policies stated above.

I hereby give Harrison Physical Therapy, P.C. permission to perform physical therapy as prescribed by my physician on myself or my child (if applicable).

Signature of patient (or guardian if under 18)

Date: _____



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FINANCIAL POLICY

Harrison Physical Therapy, P.C. is dedicated to providing you with the highest quality of care, and is willing to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to us. Please consult the office staff if you have any questions about our fees, financial policy, or your responsibility.

As a service to our patients, we at Harrison Physical Therapy, P.C. will be glad to submit your insurance claims for you. However, you are responsible for any portion not paid by your insurance. Payment is due for services at the time services are rendered. We will collect all copayments and deductibles at the time of your visit.

If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of the check. After the insurance company has paid their portion of your claim, should your financial responsibility be unpaid after 90 days, the account will be turned over to a collection agency and you will be responsible for the balance of your bill as well as any collection charges incurred.

I understand and agree to comply with the Financial Policy as explained above.

Signature of patient (or guardian if under 18)

Date: _____